Bulletin

VANDERBILT UNIVERSITY
LIBRARY
SEP 28 1961
SCHOOL OF MEDICINE

went
tholo-
edical
state
rolina
o cur-
dicine,
f ATS
ief re-
written
relat-
experi-
deeply
mem-
and is
Mitch-

VANDERBILT UNIV. SCH. OF MED.
MEDICAL LIBR.
NASHVILLE 5, TENN.

NATIONAL
TUBERCULOSIS
ASSOCIATION

Bulletin

Sol S. Lifson
Editorial Director

Lucille Fisher
Managing Editor

Jo Brown
Art Editor

Cover photo: future practitioners receiving instruction at New York Hospital—Cornell Medical Center. Photo courtesy Chas. Pfizer & Co.

VOL. 47 NO. 8

Published monthly except August at 404 North Wesley Ave., Mount Morris, Ill., by the National Tuberculosis Association for persons interested in public health and administrative aspects of tuberculosis and respiratory disease control, and made possible by Christmas Seal contributions. The editors welcome articles for possible publication. If any article deals with a subject on which there may be differences of opinion, the BULLETIN will be glad to consider presentation of varying opinions in the same or subsequent issues. The opinions expressed in signed articles are the authors' and do not necessarily reflect those of the National Tuberculosis Association. Editorial Office: 1790 Broadway, New York 19, N.Y. Second class postage paid at Mount Morris, Ill.

PROGRAMS IN MEDICAL EDUCATION:
A Changing Emphasis

■ THERE ARE TWO ASPECTS to the education of a physician: education and training. Training is primarily the acquisition of factual knowledge and techniques, while education seeks to stimulate native curiosity in order that such curiosity and resultant inquiry will persist and grow throughout life. A synonym for education is growth. No man can grow for another, but he can foster learning, understanding, and scholarship in another.

There is serious lack of financial support for the increasing costs of undergraduate medical education, but significant aid from NTA-ATS to meet the many costs appears economically impossible. The need for support of postgraduate medical education in pulmonary disease is also very great. The hiatus between that which is medically known and that which is used daily by many general practitioners is a cause of continuing anxiety to medical educators. Attempts to "teach the hard-to-reach" are met with many frustrations. The establishment and maintenance of medical faculties which can reach out into the local communities are of the utmost importance.

Because of the tremendous expense of undergraduate medical education and the frustrations in the effecting of postgraduate medical education, it appears reasonable and economically sound for NTA-ATS to focus aid to medical education upon providing support for faculty positions in tuberculosis and pulmonary disease. In October, 1960, the Committee to Review Policies on Medical Research and Medical Education recommended such support. It is clear that the pulmonary disease *teacher* who is a faculty member of a medical school and who is engaged actively in teaching, research, and patient care plays the most important role in educating and influencing medical students and physicians in the pulmonary disease field. He can train and aid in the education of the undergraduate and the graduate and he can also continue the education of the practicing physician while supplying him with factual material and information on techniques.

A significant problem exists, however, regarding the potential source of faculty members who are both qualified and interested in pulmonary disease. Some years ago, most such potential faculty members were young men and women who had experienced the threat of tuberculosis. Today, fortunately, few young physicians have faced this personal problem, but, as a result, interest in pulmonary disease has waned. The continuation of the Fellowship Program of the NTA-ATS will aid considerably in stimulating and fostering such interest and in providing future faculty members. In addition, the short-term support of individuals should be maintained by scholarships for courses and conferences and by the distribution of printed materials to medical students, residents, and practitioners of medicine.

Though several problems may arise, of which the greatest may be budgetary, efforts of the NTA-ATS, through the local and state associations, to support faculty positions in medical schools should result in the greatest potential impact upon medical education in pulmonary disease that is possible with the available funds.

—WINTHROP N. DAVEY, M.D.

University of Michigan Medical Center, Ann Arbor, Michigan

The Wisest Investment

The interest of research workers and the medical profession in tuberculosis and respiratory diseases can best be stimulated by a sharp refocusing of medical education and research programs.

Robert H. Ebert, M.D.

THE NATIONAL TUBERCULOSIS ASSOCIATION is dedicated to the control of tuberculosis and other respiratory diseases. This goal will remain unchanged until the objectives are achieved, but in a rapidly changing world the methods for accomplishing control must be under constant scrutiny. Nowhere have there been more enormous changes than in the fields of medical research and education. It was for this reason that Dr. William B. Tucker, on becoming president of the American Thoracic Society, appointed an ad hoc committee to review the ATS research and education programs with a view to determining if, within the resources available presently or in prospect, the wisest investment was being made from the standpoint of both ATS and NTA.

RESEARCH

Significance of research to the NTA

The bylaws of the NTA state that research in tuberculosis and in other respiratory diseases are primary goals of the association. Traditionally, the major effort of the tuberculosis movement has been in the field of social action, but even in this field the by-products of research are of critical importance.

Perhaps the most important by-product of research is to provide new knowledge so that new programs can be created for the control of tuberculosis and other respiratory diseases. Let us consider several examples:

As the incidence of tuberculosis falls, the tuberculin test becomes a more and more important epidemiological tool. If the tuberculin test is to be an effective instrument, we must know more about its reliability and the significance of cross reactions due to infection with mycobacteria other than the tubercle bacillus. This takes research, and research directly affects program.

Let us examine a more hypothetical possibility of research modifying program. The drugs in present use are essentially bacteriostatic agents which stop growth but do not kill all tubercle bacilli. Suppose that a bactericidal drug could be developed which could eradicate infection in one to two weeks (as, for example, it is possible to eradicate the spirochete of syphilis with penicillin). Such a discovery would alter profoundly our program of tuberculosis control.

One final example should be given in the field of nontuberculous respiratory disease. Emphysema is an important cause of invalidism and death, but we are vastly ignorant as to its cause, clinical course, prevention, and treatment. It is difficult to devise an effective program for the control of emphysema without more knowledge, and this can be attained only through research.

National resources for research

Obviously, if unlimited funds were available from the federal government, endowments, or other sources, and there were an unlimited number of research workers, there would be no need for the NTA to do anything but profit from the fruits of research supported by these sources. What are the facts? Large amounts of money are available today for research, but such funds are unevenly distributed and are directed primarily to categories of disease other than tuberculosis and respiratory disease. This means that not enough investigative work is being done in the fields which interest us. But even more important than the immediate problem of money is the matter of how many investigators are available. There are too few well-trained research workers to do all the jobs which need doing. This means there is competition for the attention and interest of investigators. For example, the well-trained virologist finds it easier to get support for the study of cancer than he does for the study of respiratory disease.

Ideally, the NTA would fill this gap. If wishes were realities, NTA would provide funds for the study of tuberculosis and respiratory disease and would successfully compete with other agencies for the interest of able investigators. The word *able* should be emphasized, since the competition is for the best minds and not simply for anyone who wishes to do research. Obviously, a voluntary health agency such as the NTA does not have and never will have enough money to support all of the research in its particular field of interest, but adequate funds spent by the NTA would provide "seed money" so that even more support could be obtained from government agencies.

MORE ▶

NATIONAL
TUBERCULOSIS
ASSOCIATION

Bulletin

Sol S. Lifson
Editorial Director

Lucille Fisher
Managing Editor

Jo Brown
Art Editor

Cover photo: future practitioners receiving instruction at New York Hospital—Cornell Medical Center. Photo courtesy Chas. Pfizer & Co.

VOL. 47 NO. 8

Published monthly except August at 404 North Wesley Ave., Mount Morris, Ill., by the National Tuberculosis Association for persons interested in public health and administrative aspects of tuberculosis and respiratory disease control, and made possible by Christmas Seal contributions. The editors welcome articles for possible publication. If any article deals with a subject on which there may be differences of opinion, the BULLETIN will be glad to consider presentation of varying opinions in the same or subsequent issues. The opinions expressed in signed articles are the authors' and do not necessarily reflect those of the National Tuberculosis Association. Editorial Office: 1790 Broadway, New York 19, N.Y. Second class postage paid at Mount Morris, Ill.

E

PROGRAMS IN MEDICAL EDUCATION: A Changing Emphasis

■ THERE ARE TWO ASPECTS to the education of a physician: education and training. Training is primarily the acquisition of factual knowledge and techniques, while education seeks to stimulate native curiosity in order that such curiosity and resultant inquiry will persist and grow throughout life. A synonym for education is growth. No man can grow for another, but he can foster learning, understanding, and scholarship in another.

There is serious lack of financial support for the increasing costs of undergraduate medical education, but significant aid from NTA-ATS to meet the many costs appears economically impossible. The need for support of postgraduate medical education in pulmonary disease is also very great. The hiatus between that which is medically known and that which is used daily by many general practitioners is a cause of continuing anxiety to medical educators. Attempts to "teach the hard-to-reach" are met with many frustrations. The establishment and maintenance of medical faculties which can reach out into the local communities are of the utmost importance.

Because of the tremendous expense of undergraduate medical education and the frustrations in the effecting of postgraduate medical education, it appears reasonable and economically sound for NTA-ATS to focus aid to medical education upon providing support for faculty positions in tuberculosis and pulmonary disease. In October, 1960, the Committee to Review Policies on Medical Research and Medical Education recommended such support. It is clear that the pulmonary disease *teacher* who is a faculty member of a medical school and who is engaged actively in teaching, research, and patient care plays the most important role in educating and influencing medical students and physicians in the pulmonary disease field. He can train and aid in the education of the undergraduate and the graduate and he can also continue the education of the practicing physician while supplying him with factual material and information on techniques.

A significant problem exists, however, regarding the potential source of faculty members who are both qualified and interested in pulmonary disease. Some years ago, most such potential faculty members were young men and women who had experienced the threat of tuberculosis. Today, fortunately, few young physicians have faced this personal problem, but, as a result, interest in pulmonary disease has waned. The continuation of the Fellowship Program of the NTA-ATS will aid considerably in stimulating and fostering such interest and in providing future faculty members. In addition, the short-term support of individuals should be maintained by scholarships for courses and conferences and by the distribution of printed materials to medical students, residents, and practitioners of medicine.

Though several problems may arise, of which the greatest may be budgetary, efforts of the NTA-ATS, through the local and state associations, to support faculty positions in medical schools should result in the greatest potential impact upon medical education in pulmonary disease that is possible with the available funds.

—WINTHROP N. DAVEY, M.D.

University of Michigan Medical Center, Ann Arbor, Michigan

The Wisest Investment

The interest of research workers and the medical profession in tuberculosis and respiratory diseases can best be stimulated by a sharp refocusing of medical education and research programs.

Robert H. Ebert, M.D.

THE NATIONAL TUBERCULOSIS ASSOCIATION is dedicated to the control of tuberculosis and other respiratory diseases. This goal will remain unchanged until the objectives are achieved, but in a rapidly changing world the methods for accomplishing control must be under constant scrutiny. Nowhere have there been more enormous changes than in the fields of medical research and education. It was for this reason that Dr. William B. Tucker, on becoming president of the American Thoracic Society, appointed an ad hoc committee to review the ATS research and education programs with a view to determining if, within the resources available presently or in prospect, the wisest investment was being made from the standpoint of both ATS and NTA.

RESEARCH

Significance of research to the NTA

The bylaws of the NTA state that research in tuberculosis and in other respiratory diseases are primary goals of the association. Traditionally, the major effort of the tuberculosis movement has been in the field of social action, but even in this field the by-products of research are of critical importance.

Perhaps the most important by-product of research is to provide new knowledge so that new programs can be created for the control of tuberculosis and other respiratory diseases. Let us consider several examples:

As the incidence of tuberculosis falls, the tuberculin test becomes a more and more important epidemiological tool. If the tuberculin test is to be an effective instrument, we must know more about its reliability and the significance of cross reactions due to infection with mycobacteria other than the tubercle bacillus. This takes research, and research directly affects program.

Let us examine a more hypothetical possibility of research modifying program. The drugs in present use are essentially bacteriostatic agents which stop growth but do not kill all tubercle bacilli. Suppose that a bactericidal drug could be developed which could eradicate infection in one to two weeks (as, for example, it is possible to eradicate the spirochete of syphilis with penicillin). Such a discovery would alter profoundly our program of tuberculosis control.

One final example should be given in the field of nontuberculous respiratory disease. Emphysema is an important cause of invalidism and death, but we are vastly ignorant as to its cause, clinical course, prevention, and treatment. It is difficult to devise an effective program for the control of emphysema without more knowledge, and this can be attained only through research.

National resources for research

Obviously, if unlimited funds were available from the federal government, endowments, or other sources, and there were an unlimited number of research workers, there would be no need for the NTA to do anything but profit from the fruits of research supported by these sources. What are the facts? Large amounts of money are available today for research, but such funds are unevenly distributed and are directed primarily to categories of disease other than tuberculosis and respiratory disease. This means that not enough investigative work is being done in the fields which interest us. But even more important than the immediate problem of money is the matter of how many investigators are available. There are too few well-trained research workers to do all the jobs which need doing. This means there is competition for the attention and interest of investigators. For example, the well-trained virologist finds it easier to get support for the study of cancer than he does for the study of respiratory disease.

Ideally, the NTA would fill this gap. If wishes were realities, NTA would provide funds for the study of tuberculosis and respiratory disease and would successfully compete with other agencies for the interest of able investigators. The word *able* should be emphasized, since the competition is for the best minds and not simply for anyone who wishes to do research. Obviously, a voluntary health agency such as the NTA does not have and never will have enough money to support all of the research in its particular field of interest, but adequate funds spent by the NTA would provide "seed money" so that even more support could be obtained from government agencies.

MORE ▶

Limited objectives

What is the reality? Unfortunately, the NTA-ATS has too little money available for research to accomplish its objective. For this reason, the ad hoc committee suggested that the research objectives of the ATS and NTA should be more sharply focused on particular areas. One such area might be problems of treatment of tuberculosis, with special emphasis on the better understanding of the tubercle bacillus and its complex relationship with the host. It was recognized that in so focusing research there would be a delay in the stimulation of work in the field of nontuberculous respiratory disease, but it was thought unlikely that enough money could be spent in this area to spark the necessary interest.

MEDICAL EDUCATION

Needs of the NTA

Clearly the NTA does not have a primary responsibility to support medical education. Why, then, should the association be concerned with medical teaching? The answer is very simple. It is vital to the success of the NTA-ATS as well as to state and local associations to have physicians in the community interested in and knowledgeable about the field of tuberculosis and respiratory disease. Interest in a particular area of medicine is usually developed during medical school or during internship and residency training, and the only way that we can have a substantial impact upon what is taught medical students, interns, and residents is through the presence of active and stimulating teachers and scholars in the field of pulmonary disease.

Need for teachers

Medical education today faces a difficult problem. A full-time medical faculty is needed to provide the best teaching, and no medical school, private or state-supported, has enough money to support all of its faculty from its regular budget. This means that it must go outside the university for additional support. The federal government is the major contributor to additional funds. Most government support is for research, however, and this means that it is possible to obtain money for the support of a faculty member who is very able and who will spend 80 per cent of his time in research, but it's very difficult to get money for a person who wishes to spend a substantial amount of time teaching. It can be argued that the support of teachers should come from the regular budget of the medical school, and this argument has validity, but regular funds are limited, and such a policy gives no guarantee that the field of respiratory disease will be well represented on the teaching faculty.

A program for tuberculosis associations

Tuberculosis associations are keenly aware of the need for more physicians in the community who have a vital interest in respiratory disease. The interest of physicians in training is stimulated by excellent teachers in the pulmonary disease field. For these reasons, the ad hoc committee suggested the following:

> The committee recommends that the American Thoracic Society and the NTA sponsor a program of providing faculty positions in medical schools, such a program to be supported at the state or local level. It is expected that the recipients of such awards would have completed all of their training and would be treated as regular faculty members of the school in which they work, participating in the regular activities of the department including teaching, research and, in the case of clinical departments, patient care. It was suggested that a moral commitment be given for initial support of five years, with the possibility of renewal. No exact formula for the selection of such faculty members was recommended, but it was suggested that there must be at least three participants. Obviously, the medical school would have to nominate the candidate. Certainly the nomination would have to meet the approval of the local or state society. In addition, however, it was suggested that for the purpose of quality control and prestige it would be advisable to have a national committee pass upon the qualifications of each candidate. The awards could be made to candidates from any department in the medical school, the only criterion for selection being that the candidate's major interest would be in the field of tuberculosis or other respiratory diseases. It was felt that the medical school might or might not provide joint support for such a position, depending upon local circumstances. This program could be instituted with or without some degree of national financial participation, but the major contribution of the American Thoracic Society would be to provide the mechanism by which state and local associations can expend funds locally available in a way in which there will be the best possible return for the money spent, and the assurance of a high quality person.

Conclusions

Because during the past decade tuberculosis associations have failed to recognize the need for more money for research, some of the initiative has been lost to organizations interested in other disease categories. As a result, there has been less investigative interest in respiratory disease than in cancer and heart disease.

The opportunity exists today to stimulate interest among students and physicians now in training by the support of teachers in the field of pulmonary disease. This need on the part of medical schools will not last forever, and it is hoped that tuberculosis associations will seize this opportunity to stimulate interest in respiratory disease by providing support for faculty in medical schools throughout the country.

Robert H. Ebert, M.D., is president of the American Thoracic Society and recently served as chairman of the Committee on Research and Medical Education. Dr. Ebert is chairman of the Department of Medicine, Western Reserve University, and director of Medicine, University Hospitals of Cleveland. He is known for his use of hormones in the treatment of TB and for the development of a rabbit's ear chamber as a research technique.

Ten Years Later—

■ FELLOWSHIPS have been awarded by the National Tuberculosis Association since 1948, when the research program of the NTA was reorganized and expanded.

What has happened to the young men and women who completed their formal training in the yesteryears? Have they justified the faith of the voluntary health movement in them? The only way to answer these questions is to take a look at their records today. The *Bulletin* checked up on a sampling of those who were fellows approximately 10 years ago. Here is what it learned—

▸ MARJORIE M. PYLE, M.D., was forced to renounce the second year of her NTA fellowship. The reason—tuberculosis.

Dr. Pyle had held a fellowship the preceding year and had been a valuable member of the Mayo Clinic-Mineral Springs Sanatorium group in Minnesota during the early, exciting streptomycin days. She herself was working much of the time from a hospital bed at the Mineral Springs Sanatorium. However, all seemed to be going well until she had a relapse. Her doctor advised an operation and no more work. Good patient that she was, she gave up the fellowship and the work.

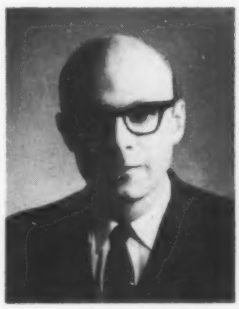
Patience was rewarded. The operation was a success. Before long, Dr. Pyle left the sanatorium to go to the Chicago State Tuberculosis Sanitarium, this time as a staff member.

Today Dr. Pyle is chief of medicine at the Chicago institution and assistant clinical professor of medicine at the University of Illinois College of Medicine. Her chief professional interest now, as when she was working in Minnesota as an NTA fellow, is the chemotherapy of tuberculosis.

▸ ARTHUR M. DANNENBERG, JR., M.D., began his postgraduate studies as an NTA fellow at the Henry Phipps Institute of the University of Pennsylvania, Philadelphia, working under Max B. Lurie, M.D., who is well known for his unique studies of the role of constitutional factors in immunity to tuberculosis. Since then, Dr. Dannenberg has rarely been able to tear himself away from tuberculosis research.

After two years at the University of Utah School of Medicine, Dr. Dannenberg served in the U.S. Naval Reserve. Attached to a medical research unit, he was engaged in research in experimental microbiology and immunology. He then returned to Henry Phipps where he is now assistant professor of experimental pathology.

He is engaged in research on the intracellular enzymes involved in the resistance to allergic and infectious diseases, particularly tuberculosis.



▸ DONALD L. BRUMMER, M.D., has had an active decade in the tuberculosis field since he was first granted an NTA fellowship in 1949. At that time, he was studying the clinical aspects of a rehabilitation program and the evaluation of various features of bed-rest therapy under the direction of J. Burns Amberson, M.D., at Bellevue Hospital, New York.

Dr. Brummer is now assistant professor of medicine at the Medical College of Virginia and is also medical director of the Sanatorium Division of the Ennion G. Williams Hospital, located at the college. He lectures not only on tuberculosis but on other respiratory diseases.

Along with his professional duties, Dr. Brummer has been an active volunteer in the tuberculosis field. He is a past president of the Virginia Thoracic Society and has recently been chosen a representative councilor of the American Thoracic Society.

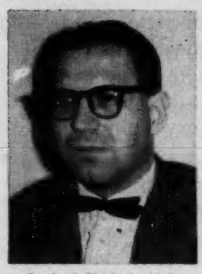
▸ QUENTIN N. MYRVIK first received an NTA fellowship while studying for his Ph.D. at the University of Washington in Seattle. After receiving his Ph.D., he went to the University of Virginia in 1952 as acting assistant professor of microbiology in the department of microbiology of the School of Medicine.

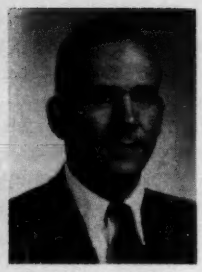
Today Dr. Myrvik is associate professor of microbiology at the university and has gained an international reputation for studies that grew out of observations made as an NTA fellow—that a factor found in the serum of rabbits immunized against tuberculosis was lysozyme (a substance similar to the protein in the white of an egg).

Dr. Myrvik has continued research in tuberculosis. He is also actively engaged in teaching. So rapidly has Dr. Myrvik advanced in his chosen field that this fall he will have three post-doctoral fellows and one graduate student training under him.

—AGNES FAHY

NTA-ATS Fellows


Sanford Chodosh, M.D.


David W. Cugell, M.D.

Roger M. Des Prez, M.D.

Marvin J. Allison, Ph.D.

David M. Carlberg, Ph.D.

C. W. Jordahl, Jr., M.D.

Harold Levine, M.D.

Paul M. Stevens, M.D.

John M. Tyler, M.D.

Alfred A. Azzoni, M.D.

This year, through the NTA-ATS Fellowship Program, 26 young investigators and teachers are in training at 22 medical centers. Financial support of individual fellows is shared with 16 tuberculosis associations in 11 states. Fourteen fellows are starting their training in pulmonary diseases this year; twelve are continuing their fellowships. They are:

EDWARD LIVINGSTON TRUDEAU FELLOWS

▸ Sanford Chodosh, M.D., instructor in medicine at Tufts University School of Medicine, Boston, is continuing his work with Dr. Maurice S. Segal in the Lung Station of the Boston City Hospital. Primarily a clinician, he is also carrying on studies in tuberculosis and bronchitis, and on the pigeon as a vector of cryptococcosis.

▸ David W. Cugell, M.D., Potts Memorial-Edward Livingston Trudeau Fellow, now in his fourth year, is assistant professor of medicine at the Northwestern University School of Medicine, Chicago, and chief of staff, Medical Chest Service of the Cook County Hospital. He also carries on an active program of research in ultrasound, electromyography, and audio frequency methods of physical diagnosis and in diffusion capacity in certain lung diseases.

▸ Roger M. Des Prez, M.D., continues his fellowship as an instructor in medicine at Cornell University Medical College, New York, under Dr. Carl Muschenheim. He is physician to outpatients and also cares for patients in New York Hospital. He is carrying on studies on the antigen-antibody reaction.

RESEARCH FELLOWS

▸ Marvin J. Allison, Ph.D., is a research associate in the Henry Phipps Institute of the University of Pennsylvania, Philadelphia, continuing his work under Dr. Max B. Lurie. His field is experimental pathology with special interest in the relationship between inborn constitution and resistance to infections.

▸ David M. Carlberg, Ph.D., the Harold Trimble Memorial Fellow, is a research assistant to Dr. G. J. Jann in the department of bacteriology at the University of California at Los Angeles, and is on his second year of fellowship. He is studying the basic components of the tubercle bacillus and other mycobacteria by bacteriophage techniques.

▸ Clarence W. Jordahl, Jr., M.D., who previously held a teaching fellowship, is now starting a year of training in investigative techniques in pulmonary function with Dr. Robert E. Forster at the Graduate School of the University of Pennsylvania.

▸ Harold Levine, M.D., is in his second year of fellowship at Northwestern University School of Medicine, Chicago, under Dr. Cugell. He is also an assistant attending physician at the Cook County Hospital. His research concerns pulmonary diffusion and cardiac outflow in various diseases.

▸ John M. Moses, M.D., an instructor in the department of medicine at Western Reserve University, Cleveland, is starting a fellowship to work under Dr. Robert H. Ebert on the relationship of tuberculin fever to tuberculin sensitivity.

▸ David Y. Rosenzweig, M.D., starts his research fellowship at the Webb Institute for Medical Research of the University of Colorado School of Medicine, Denver. He will be working under Dr. Giles Filley on physiologic studies of isolated lung preparations and on a long-term study of emphysema patients.

▸ Paul M. Stevens, M.D., is the new C. Hartwell Cocke Fellow, working under Dr. John H. Knowles at the Massachusetts General Hospital, Boston. He will be engaged in research studies in the pulmonary physiology laboratory of that hospital, and he will follow patients in the wards and in the chest clinic.

▸ John M. Tyler, M.D., instructor in medicine at Tulane University School of Medicine, New Orleans, starts his investigation work under Dr. M. M. Ziskind. He plans to study lung function in families with inherited connective tissue disorders.

TEACHING TRAINEES

▸ Alfred A. Azzoni, M.D., is a thoracic surgical resident at the Columbia-Presbyterian Medical Center, New York, and chief resident of the Surgical Services under Dr. Robert H. Wylie. He is continuing his training in thoracic surgery in both clinical and laboratory phases.

1961-1962

Donna O'Hare Brayton, M.D., assistant in pediatrics at the New York University School of Medicine, New York, is starting a year of teaching under Dr. Saul Krugman and of clinical investigation in the pediatric chest clinic at Bellevue Hospital.

Harry A. Edwards, Jr., M.D., resident in medicine at the Jackson Memorial Hospital in Miami, will be teaching under Dr. C. F. Tate at the University of Miami School of Medicine and carrying on a follow-up study of operated and non-operated cases of bronchogenic carcinoma.

Richard H. Evans, M.D., resident in surgery at the University of Chicago, is being trained in pediatric cardiopulmonary surgery under Dr. Peter Moulder.

Ronald Feldman, M.D., assistant instructor in medicine at the Albert Einstein College of Medicine, the Bronx, New York, is starting his traineeship under Dr. M. Henry Williams at the Bronx Municipal Hospital. He will work in the wards and in the pulmonary function laboratory.

Robert I. Fraser, M.D., medical resident at the Pennsylvania Hospital in Philadelphia, is carrying out his ward and outpatient duties under Dr. E. Wayne Marshall and assisting in teaching medical students and nurses.

Rafik T. Hubaytar, M.D., chief resident on the Chest Service at Bellevue Hospital, Columbia University Division, New York, will complete his training in pulmonary diseases under Dr. John H. McClement. He will later return to Lebanon and the American University of Beirut to teach.

Donald R. Kahn, M.D., having completed his four years of surgical residency at University Hospital, Ann Arbor, Michigan, is continuing to work under Dr. Cameron Haight on the problem of lung transplantation.

Linda Leilop, M.D., assistant instructor, department of medicine, Pulmonary Disease Section, State University of New York Downstate Medical Center, Brooklyn, New York, continues her fellowship under Dr. Harold A. Lyons. She teaches medical students and also works on clinical problems involving steroid therapy and sputum examination.

Donald J. Massaro, M.D., Pulmonary Fellow of the Georgetown Medical School, Washington, D.C., is continuing his training in teaching and clinical research under Dr. Sol Katz. He is working in the wards and in the pulmonary function laboratory on problems involving emphysema.

Raymond F. Medler, M.D., instructor in medicine, State University of New York Downstate Medical Center, Brooklyn, New York, and assistant visiting physician at Kings County Hospital, continues his fellowship under Dr. Harold A. Lyons with charge of tuberculosis beds and clinical research in therapy, preoperative evaluation, and pleural biopsies.

Eleanor S. Nash, M.D., having completed a year as chief resident on the Chest Service, Bellevue Hospital, New York, under Dr. John H. McClement, has started another year of fellowship as a member of the Cardiopulmonary Research Unit (Columbia University Division).

Jourdan A. Roane, M.D., resident in pediatrics, University of Oklahoma Medical Center, Oklahoma City, is starting his first year of traineeship and second year of residency under Dr. H. D. Riley, Jr. In addition to teaching and ward duties, he is studying fungus infections involving children's lungs.

Murray Sachs, M.D., previously Teaching Fellow in Medicine at the University of Pittsburgh, is taking a year of traineeship under Dr. Sol Katz at the Mt. Alto Veterans Administration Hospital, Washington, D.C., to be spent in the pulmonary physiology laboratory and chest wards.

Donald W. Smith, M.D., Fellow in Chest Diseases, University of California Medical Center, San Francisco, is starting his traineeship under Dr. Charles T. Carman. He will teach, prepare weekly chest conferences, cover ward rounds, and follow outpatients with chronic pulmonary disease.

Harry A. Edwards, Jr., M.D.

Ronald Feldman, M.D.

Robert I. Fraser, M.D.

Rafik T. Hubaytar, M.D.

Donald R. Kahn, M.D.

Linda Leilop, M.D.

Donald J. Massaro, M.D.

Eleanor S. Nash, M.D.

Jourdan A. Roane, M.D.

Donald W. Smith, M.D.

Tuberculosis Means People–

The Delaware County Study

Irving W. Shandler

■ HOW MUCH DO TB ASSOCIATIONS know about the TB patients in their areas? How many of the statistics that appear after X-ray surveys are ever translated into the human drama inherent in the discovery of each case of TB? What physical, emotional, social, and vocational problems are created for the patient or his family by the diagnosis of TB? Do we in the TB field fully accept the fact that tuberculosis means *people* – individuals whose normal course of life has been interrupted with a jolt?

These were some of the questions discussed by representatives of the Delaware County Tuberculosis and Health Association and the Pennsylvania Tuberculosis and Health Society in the late summer of 1959. From this discussion, plans emerged for a study to be conducted in Delaware County to determine the social and psychological characteristics of the TB patients who are in the case register; to mark out areas in which the patients or their families might need help; and to gather data that could be used by the TB association in evaluating its program of TB control in relation to the community picture.

Development of the study project

The plan was discussed with the Bryn Mawr College Graduate Department of Social Work and Social Research. With their excellent cooperation, a doctoral candidate contracted to serve as the study director.

In order to finance the project, a request was made to the Joint Rehabilitation Fund of Pennsylvania Tuberculosis Organizations. This fund is supported by all TB affiliates in Pennsylvania and has been used over the years to promote rehabilitation services throughout the Commonwealth.

Prior to the study, Marjorie M. Farley, the study director, spent considerable time becoming oriented to the TB field, meeting with various community agencies and discussing the project with the Pennsylvania Department of Health and the county medical society.

The county selected for the study was an ideal laboratory for research. It is small, lies next to Philadelphia, and has a population of over 500,000. The areas it embraces run the gamut from the heavily urbanized and industrialized city of Chester to the suburban and rural areas surrounding Philadelphia. A random sample of fifty cases was taken from the county case register of 487 names.

The project, as it evolved, concentrated on determining the patient's obvious problems; the social and psychological characteristics of the patients, and determining which personal characteristics influence adherence to schedules for medical check-up.

The study was designed so that all interviews were conducted by the study director, a trained social worker. All interviews were held in individual homes. Each patient was asked the same set of questions. *No patient refused to be interviewed.*

Characteristics of the patients

Briefly, as might be expected from other observations, these are the characteristics of the patients:

–In comparison to the general population, the TB group tended to be older, to have less general education, to live under poorer socio-economic conditions, and to have a higher rate of nonwhites to whites.

–Seventy-six per cent of the patients interviewed lived in the three most densely populated areas of the county. (Estimates for 1957 indicate that 50 per cent of the county population lives in these three areas.) Twenty per cent of the patients lived in one census tract in Chester. Here, the majority of homes were crowded and run-down and had neither running water nor private baths.

–Less than a quarter of the patients were employed. Of those who were working, most had acquired special skills and experience *prior* to their illness. One out of every four families was existing on a substandard basis. The midpoint weekly income for white patients was $29; for nonwhites it was $15.

What influences the patient's follow-through with treatment?

The principal aim of the study was to discover which factors had an influence on whether or not the patient followed through with his TB medical treatment plan.

Of all the factors tested to determine whether a significant relationship to follow-up medical care existed, only

two proved to be significant at a "high degree" of statistical validity. These were *education* and *knowledge of disease*.

While the general educational level of the patient population was lower than that of the county as a whole, it was shown that those with the higher educational achievements participated more actively in medical follow-up programs.

A person's knowledge of disease also proved to be a strong indication as to his participation. The better the knowledge exhibited, the more certain one could be of the patient's participation.

There was some evidence that education and knowledge of disease were sometimes found in the same people, but this was not always the case.

While only the two factors noted above had the highest statistical correlation, several other factors had a lesser correlation but still demonstrated a significant influence on participation in follow-up services. It was found that, generally, patients currently married, living in a family-owned home, and having a positive attitude toward life tended to follow medical care programs better than those who did not have these characteristics.

The factors that showed *no* significant correlation were sex, age, ethnic background, reaction to authority, geographic stability, socio-economic position, employment status, place of follow-up care, activity status, and TB hospital experience.

It is interesting to note that although knowledge of disease was a key factor in getting people to participate in their care, this knowledge was not dependent on the amount of health literature to which they had been exposed.

The patients' problems

The second major aim of the study was to discover the patient's problems as seen by himself and his family. Grouping the results, the study indicated that about 70 per cent of the patients have problem areas *in addition to* the health problems caused by the TB. These can be listed in the following overlapping categories:

Insufficient income	44%
Unsuitable housing	53%
Other health problems	30%
Personal or social adjustment needs	55%

Groups with specific problems

Another way of reviewing the results of the study is to define specific problem groups. Here, two groups merit particular attention—women not currently married, and fathers and husbands.

The women who were not currently married had, in many cases, the sole responsibility for raising children. Although in numbers, the problem was not always a large one, the plight of these women was often tragic. What added to the pathos was the effect on the children.

Example: Mrs. A., age 43, deserted by her husband, struggles to maintain her seven children (6 months to 10 years old) on an Aid to Dependent Children grant which amounts to approximately $51 weekly. Her rent of $18 weekly does not include heat, light, or water, and despite expenditures of $15 monthly for fuel, the drafty house is not comfortably heated. Afflicted with arthritis, stomach ulcer, and bad teeth which should be extracted, Mrs. A. maintains a busy schedule caring for her poorly equipped house and doing a great deal of sewing. She seldom associates with neighbors, has never had friends. There is neither time nor money for recreation. A high school graduate, Mrs. A. cannot consider seeking outside employment.

The father and husbands group also present a key picture because of the involvement of total families. These men appear to set up two reactions to their illness, both in need of psychological help. In some cases the man refuses to acknowledge his health improvement and delays assuming his appropriate responsibilities. In other situations, the man is so eager to prove that his illness is no handicap that he overextends himself, spending long hours at several jobs.

Example: Mr. W. drives a truck and earns good wages, but bills amounting to more than thirty weeks' earnings are still a cause of constant worry. The family, which includes four children aged 2 to 8, moved recently, partly to be in a neighborhood where none would know of Mr. W.'s having had tuberculosis. The home which they are buying is already not quite large enough, and Mr. W. plans to renovate and increase their living space. His wife, for whose sake he claims he left the sanatorium against medical advice, is again pregnant.

The unattached males and older patients did register problems in the areas of housing and recreation, but not with the magnitude of the first group.

Example: Mr. L., 58, lives alone on the first floor of a two-apartment house which he has owned since his parents died. Limited in education and comprehension, his contacts with the clinic seem to be a high point in a shallow but apparently comfortable enough existence.

Example: Mr. N., 74, widowed, lives alone rent-free in the basement of a commercial building owned by his brother. Minus one forearm, he manages to do his own shopping and prepares sketchy meals for himself, supplemented at times by food brought in or meals at the home of his relatives. His lack of schooling and faulty English interfered with his comprehension of many questions.

The married women presented few obvious problems to the researcher. However, there was a strong indication that more intensive interviewing would have revealed strong psychological reactions to the tuberculosis.

Example: Mrs. Y., 22, was married in July 1958 and in the following month went to a sanatorium where she remained until November 1959. There is no evidence that she and her young husband received any adequate preparation as they set up housekeeping in the small apartment they have found in a town strange to both of them. A clerk-stenographer, she frets at her inability to find a

part-time job to help pay for their car and household furnishings, while a large bottle of PAS pills stands on the new breakfast table as a constant reminder of her limitations.

Th last category, children, presented the fewest problems, in number. Here, though the situations varied depending on the attitude of the parents, the cases indicated a disruption in these young people's lives. Without outside help, these disruptions could have serious consequences.

Example: Joan, aged 15, is an only child. Her father's earnings are sufficient to provide his family with "everything they need" in their attractive, six-room home in a fairly new suburban development. Her parents, aunts and uncles panicked when a school examination three years ago revealed her tuberculous infection. While she does have regular check-ups, drinks two quarts of milk daily, and maintains a schedule of nine hours' sleep nightly, the family tries to minimize limitations on her activities and cautions her not to mention the illness to neighbors or school friends.

Meaning for TB associations

What does all of this mean to a TB association? In Delaware County, a committee of board members and key community people have been holding a series of meetings to translate the findings of the study into community action. In addition, we feel that the findings in Delaware County have implications for all TB associations. In general, we would like to say this:

Health Education. There is a need to evaluate the entire area of pamphlets and other printed materials that are patient oriented. Few patients remembered having seen much of the material, and those who did remember indicated little knowledge of the content. There was no correlation between exposure to health education materials and knowledge of disease. The rather low educational level of the patient group, too, suggests a need for new techniques to reach the patient.

Rehabilitation. There is strong evidence that patients need to be made more aware of the agencies in the community which exist to serve them. The agencies, too, need to be familiarized with the latest medical data related to TB and some of the particular problem areas of the tuberculous. Above all, *someone is needed to assume responsibility* for the patients' "continuity of care." The biggest gap in TB control today exists in the area of *para*-medical services. Talking about the need doesn't get these needs met. It takes time and responsible persons to see that these needs are met.

Social Research. TB associations must accept the challenge of studying the non-medical aspects of the TB problem. They need to accept social research as a necessary technique of their program and should not regard it as an anathema.

Community Action. We cannot talk about the tuberculous alcoholic without endorsing community programs for alcoholism. We cannot deplore the pathetic substandard living conditions of the TB family without supporting action for slum clearance and low-cost public housing. We cannot feel sorry for the tuberculous person attempting to exist on a pitiful public assistance grant without accepting the broad need to upgrade all levels of assistance. And this list could go on to include recreational facilities, halfway houses, homemaker services.

The TB society is an old and honored agency. In the past it has exhibited exciting leadership in the crusade to better the lot of its fellow man. Today, this challenge is still there. The association must recognize that those who have TB are *people* with the multitude of everyday problems *plus* TB.

A basic question that each TB society must ask itself is, "To what extent does our organization have a responsibility for recognizing and promoting adequate service for the tuberculous?"

Now perhaps as never before, there is an urgent need for dynamic thinking and action. This is our historic responsibility. ✱

Irving W. Shandler has been director of patient services with the Pennsylvania TB and Health Society since September, 1957. Formerly he served as an Army medical social officer in the Tuberculosis Service at Valley Forge Army Hospital. He holds a B.A. in sociology from Temple University, an M.A. in sociology from the University of Pennsylvania, and an M.S.S. from Bryn Mawr College.

Regional Conferences

Western Tuberculosis Conference
September 21-23
Newhouse Hotel, Salt Lake City, Utah

Mississippi Valley Conference
October 12-14
Sherman Hotel, Chicago, Illinois

Northeastern Tuberculosis Conference
October 26-27
Statler Hilton Hotel, New York City

Southern Tuberculosis Conference
September 6-9
Arlington Hotel, Hot Springs, Ark.

The Community Hospital:

Continuing Education in Respiratory Diseases

Edmund D. Pellegrino, M.D.

WITH THE DISCOVERY of effective and specific antituberculosis drugs, the care of increasing numbers of tuberculosis patients will be transferred from the sanatorium and the chest specialist to the community hospital and the general physician. However, as Walsh McDermott has emphasized, such transfer calls for the education of general practitioners, internists, administrators and other health personnel for their new responsibilities in the management of this complicated chronic illness.[1]

To be effective, such education must be directed at the physician in his own community hospital and must be based in the care of his own patients. There is a need first for basic, and then for continuing, education in chest medicine and tuberculosis. If this need can be met, the patient will gain from the return of his care to the family and the community where, ideally, the majority of medical problems can be handled in a comprehensive fashion.

The importance of education in "chest medicine" and not in tuberculosis alone cannot be underestimated. If tuberculosis treatment programs in community hospitals are to succeed, tuberculosis should be managed in relationship to the other pulmonary diseases ordinarily encountered in community medical practice. This need is especially apparent since the availability of specific and effective antituberculosis agents greatly increases the physician's responsibility for the precise diagnosis of pulmonary lesions. Any recommendations, therefore, for the care of tuberculosis by the general physician must be predicated on the acquisition of sufficient familiarity with the principles of chest medicine to permit prompt etiologic identification of all chest lesions. Such knowledge will prevent misuse of potent drugs in ill-planned therapeutic trials.

The former isolation of TB patients in sanatoriums has left a deficiency in the education of those who are not chest specialists regarding the orderly procedure in the diagnostic work-up of pulmonary disease. As a result, neither the family physician nor the internist has been sufficiently prepared in the modern management of tuberculosis to assume his new role. Some physicians have come to regard a diagnosis of tuberculosis, or even the suspicion of this disease, as sufficient reason for terminating work-up or transferring the patient to a sanatorium. Not a few patients with fungal disease, carcinoma or bronchiectasis have spent time in sanatoriums, exposed to tuberculosis, because a few simple diagnostic procedures were not performed.

It is particularly important to communicate that modern tuberculosis therapy involves many measures in addition to drugs, such as the judicious use of surgery, rest, rehabilitation, and preventive, social and public health measures.

If this new community responsibility is to be undertaken properly, the family practitioner and the internist will be charged with two important roles. The first is to acquaint themselves with all aspects of the total care of tuberculosis, and the second is to take leadership in the education of colleagues, administrators and boards of trustees in the requirements for such care in the community hospital. To enable community physicians to fulfill these two responsibilities, better measures must be available to bring them up to date on recent changes in the management of tuberculosis.

There are refresher courses, films, tapes and symposiums in abundance. But these are relatively ineffectual postgraduate educational devices. They require only passive participation on the part of the physician, and their effects are consequently short-lived. They will continue to be useful but less important measures.

The most effective education for the practicing physician, outside of the reading he does for himself, is that which is based in the problems of his own patient. The opportunity to evaluate one's own patient, to arrive at decisions regarding pathogenesis, management and diagnosis and then to subject these decisions to criticism and discussion is a most productive means of continuing education. Any authoritative opinion then becomes pertinent, since the physician is himself actively committed to the diagnosis and treatment of a particular case. He is also motivated more directly to learning by the immediate benefits to his patient from the increase in his ability to manage the illness in question.

I have described elsewhere my experience and that of my colleagues with this type of teaching in the major branches of medicine and surgery in a rural community hospital in Hunterdon County, New Jersey.[2] Since 1953, the Hunterdon Medical Center has been engaged in the continuing education of the physicians of the community

[1] Walsh McDermott, M.D., "The Enlarging Role of the General Practitioner in Tuberculosis Therapy," *Journal of Chronic Diseases*, August, 1955, pp. 234-238.

[2] E. D. Pellegrino, M.D., "The Role of the Community Hospital in Continuing Education—the Hunterdon Experiment," *Journal of the American Medical Association*, May 25, 1957, pp. 361-365.

based in daily teaching around their own patients and their current clinical problems in office and hospital.

Chest disease also has been diagnosed and managed on the general medical service of this community hospital. The general practitioner has learned how to handle tuberculous and nontuberculous diseases under the supervision of a full-time specialist staff while at the same time preserving his role as attending physician. The result has been an increase in his ability to handle all types of chest diseases. While all the details of the Hunterdon plan are not applicable to other communities, the principle of teaching rooted in a physician's current clinical problem has been well demonstrated. The application of similar methods in teaching chest medicine and tuberculosis appears to be feasible.

Certain specific mechanisms may be employed in order to achieve this goal of physician education in chest disease centered in the community hospital and focused on the physician's own problems. With the cooperation of medical schools, medical societies and governmental and voluntary health agencies, the necessary consultant teachers and finances could be made available to each community hospital. One or two days a month might be spent by traveling consultants to review pulmonary problems presented by attending physicians. A plan of management could be worked out, and follow-up or progress reviewed on subsequent visits. A didactic or practical session could also be presented by the consultant. Each session could be followed by rounds on the pulmonary patients or by an X-ray conference.

The medical school has an important contribution to make here. It should make experience in tuberculosis and chest medicine a part of the experience in general medicine for its undergraduates and house officers. It should encourage and provide teacher consultants who would visit community hospitals on a regular basis to review cases and instruct in proper diagnostic techniques.

These sessions would exemplify small-group teaching of the highest order. The teacher would have his reward in thinking of the number of patients to whom each doctor will apply his new knowledge rather than in the size of the group he teaches.

A lasting measure would be to send several community physicians to a medical center for three to six months of residency in chest medicine and pulmonary tuberculosis. These men could then stimulate organization of teaching functions and consultation visits. Eventually they might be able to act in a local consultant capacity, and the visiting consultant or faculty member would need to visit less frequently. Such specially trained community physicians could also provide continuity of advice in the interim between visits of the consultant.

Another useful device would be to enlarge the functions of hospital infectious disease committees to include review of the management of pulmonary tuberculosis. Better still, committees made up of generalists, chest surgeons, radiologists and pathologists could be formed in order to consider the diagnosis and management of patients with chest disease in the same interdisciplinary manner that tumor clinics operate.

All such education must combat the tendency to sole reliance on drug therapy. Good tuberculosis management requires the coordination of preventive, rehabilitation and public health measures.

Such measures as the ones I have suggested, modified to meet local requirements, can serve as a nucleus to crystallize interest in chest problems in the community hospital. Where teaching and mutual review of patient progress take place, there is inevitably improvement in medical care.

Ultimately the most effective postgraduate education is that which improves the care that the physician renders in his own office and in the patient's home. The provision of the highest standards of care in the hospital in which the physician practices, and the opportunity of contact and consultation with a teacher-consultant around the care of his own patients, can be first steps toward such education.

The ultimate aim of medical research is to bring to each patient the full benefits of new knowledge in his own community. As a consequence, the community hospital is evolving from a primary concern with episodic acute illness to a more comprehensive approach to the total health of the individual and the community.[3]

The growing movement in the past decade toward the transfer of care of the tuberculous patient from the sanatorium and the specialist to the community hospital and the general physician exemplifies some of the practical and educational problems engendered by the discovery of specific and effective therapeutic agents. A similar transition and similar problems are being encountered in the care of the emotionally ill.

The return of the care of the patient with tuberculosis to the mainstream of medicine in the community will be beneficial. The patient will now be able to maintain contact with his family, job and community while he receives specific treatment. His general medical care will be improved and more comprehensive, and his progress toward rehabilitation speeded. Yet, if the full potential of this transfer is to be realized, there are problems which have not yet been adequately planned for by the community hospital or its physician staffs. «

E. D. Pellegrino is professor and chairman of the Department of Medicine, University of Kentucky. Prior to his present appointment, he was professor of clinical medicine, New York University. He has also served as director of internal medicine, Hunterdon Medical Center, Flemington, N.J., and as supervising TB physician, Homer Folks Tuberculosis Hospital, Oneonta, N.Y. He received his M.D. from N.Y.U.

[3]E. D. Pellegrino, M.D., "The Role of the Local Community in the Development of Health Services—the Hunterdon Experiment," *Industry and Tropical Health, IV* (Boston: Harvard School of Public Health, 1961).

The American Public Health Association

Typical of the scope of APHA publications: top center, the *Control of Communicable Diseases in Man*, a manual of procedure in world-wide use; top right, *Health Supervision of Young Children*, a manual of practice; bottom center, *Standard Methods for the Examination of Dairy Products*, a laboratory manual; bottom right, *Public Exposure to Ionizing Radiation*, a technical report. At the left is the *American Journal of Public Health*, which provides a constant flow of scientific data and materials useful as guides in public health programs.

Berwyn F. Mattison, M.D.

■ When the *New York Times* saluted the founding of the American Public Health Association in September 1872, it chose to emphasize certain qualities of the infant APHA which have proved to be lasting and true. The *Times* stated:

> "We trust the (American) Public Health Association will prove worthy of its title and of the formidable list of committees to which the leading subjects which it undertakes to investigate have been referred . . . . We hope that the Association will direct its attention to the educating of public sentiment as well as to the furnishing of scientific data."

Objectives and Early Beginnings

The objectives of the Association are to protect and promote the public health. These were its goals even before the dawn of bacteriological science and the growth of local health services which that science would help foster. Six founders led by Stephen Smith, M.D., having conceived these objectives, recognized the need for an organization to carry them out. Thus did APHA come into being as the professional home that welcomes all persons working primarily with the health of the people. The Association provided them with a scientific forum at the right moment in history. Pasteur, Lister and others were about to come to the fore with their revolutionary discoveries that made it more realistically possible to protect the public health.

Leading those who flocked to the Association during the first three decades of its existence were laboratory workers who were seeing for the first time the causes of many communicable diseases. As a result of the new discoveries in bacteriology, sanitarians also, for the first time, had been given effective knowledge and the tools with which to apply it. Sanitarians, too, used APHA as their rallying ground. As a result, the oldest of APHA's professional sections are those for laboratory workers, engineers, sanitarians, health officers and vital statisticians whose work assumed new meaning as the body of science waxed stronger under APHA's aegis.

APHA's subsequent history and manifest destiny is interwoven with what public health workers do. "Public" is the key word in APHA's title. And the key to its philosophy is that the people as a whole—in community—are the "patient" of the public health worker. While individuals must receive personal health care, persons in groups large or small need, at the same time, care that is broad in its civic effects.

To oversimplify with classical example, public health strives to get to the community before an epidemic of a preventable disease does. If public health loses this head start, it then steps in to control the epidemic with its epidemiologists (medical detectives), health officers (administrators), other physicians, laboratory workers, nurses, sanitarians, health educators and other members of the health team. The knowledge gained from such experience is made available to professional colleagues through the scientific forum of APHA.

Leading Subjects

Control of the communicable diseases remains a problem even when these diseases are preventable. Today, however, public health has to deal with diseases and conditions for which effective prophylactic and therapeutic measures are still in the making.

The gauntlet is always being thrown at the feet of American public health workers in the form of newly emerging leading subjects in public health. For example, a now longer-lived populace, preserved by and large from the ravages of communicable diseases, has become increasingly subject to the degenerative conditions caused by cancer and heart disease. In addition, man has succeeded in making a hazard of his environment with its

polluted air and waters and ionizing radiation. Moreover, he has become more aware of his mental health needs, subject to more physical injury, and finds it increasingly expensive not to preserve his health.

Spoiling for a fight with these new kinds of health problems, APHA in 1956 convened a special Task Force to map out public health strategies for advancing the cause of health. New lines of attack resulted from answers to such important questions as "Where are we going in public health?" and "How should APHA change in function and structure to remarshal its resources in orderly strength and depth on all fronts?"

All roads in public health lead back to the community, and new approaches are no exception. The Task Force, in effect, restated APHA's tenet that the community is the patient it serves. However, the new patient that the Task Force envisioned would be active rather than passive in promoting public health. Indeed, the Task Force created a new leading public health subject when it said, "A major task of public health is to increase the competence of individuals, families and communities to cope with their own health problems. . . ." The problems it chose to stress involved accident prevention, child health, chronic disease and rehabilitation, environmental health, mental health, medical care administration, public health administration, radiologic health and emergency health services.

With these problems as a starting point, the APHA then instituted a system of balanced activities, acting on Task Force recommendations. In effect, the counterbalances are groups of expert members which on the one hand develop community programs for meeting emerging health problems (Program Area Committees), and on the other develop the professional program of APHA in such broad areas as evaluation and standards, professional education, public policy and legislation, and research. The built-in equalizers for these activities are the 13,500 members of APHA who distribute themselves into 14 sections according to professional discipline or special interest. In all, some 10 per cent of APHA's members are active on its formidable list of 200 working committees.

Association Plays Variety of Roles

As a scientific forum, APHA is called upon to play a variety of roles. In its capacity of *author and publisher* to the profession, APHA puts out the monthly *American Journal of Public Health* which has a circulation of about 17,000 among public health workers, health institutions and libraries around the world. Its scientific articles provide a continuing refresher course in every aspect of modern public health practice. About half these articles originate as presentations at APHA's Annual Meeting, an unparalleled opportunity for continuing education to the serious professional worker. The *Journal's* "News from the Field" column tells of recent developments of significance in the field, and its bibliographies provide an amazingly rich store of resource material.

The Program Area Committees mentioned above are continually producing authoritative manuals of procedure in practically every phase of public health work. Typical examples are the manual, "Chronic Disease and Rehabilitation—A Program Guide for State and Local Health Agencies"; and a series of important guides and manuals for maternal and child health programs. A textbook on accident control programs is being published. And a guide for mental health technics in public health practice is nearing completion. Special committees of the Association likewise prepare procedural guides like the "Control of Communicable Diseases in Man" (now in its 9th edition and translated into 10 languages) and the "Control of Malnutrition in Man," a new twin publication to the foregoing, which should be of particular interest to our South American, Asian and African colleagues.

Another widely used category of publications of immeasurable help to the practitioner in the field is a series of statements of standards for examination of water and waste water, food, milk, and dairy products, poultry and housing.

The Association is also an *accreditor and examiner*. As such it influences the quality of professional workers in the field and through them the quality of scientific data disseminated. The Association, working with its Committee on Professional Education, accredits fourteen graduate schools of public health in this hemisphere, eleven of these in the continental United States, two in Canada and one in Puerto Rico. The same committee also develops statements of educational qualifications for a wide variety of personnel categories of public health work.

The Professional Examination Service is the largest source of objective testing available in the field of public health in this country. One of its major responsibilities is test development. For this it draws on outstanding public health scholars as consultants. On a service basis, PES last year handled a volume of 860 tests given to some 20,000 individuals for 139 agencies. Most of these tests are provided for merit system and civil service agencies with responsibility for selecting candidates for work in official health departments. The PES also provides service to a number of state examining boards (for instance in the field of medicine, veterinary medicine and physical therapy) as well as the certifying examinations for the American Board of Preventive Medicine.

APHA is also an *explorer* of new ways to protect and promote the public's health. Its non-stop efforts to provide stimulation for progress to these ends are seen in many of the articles published in the *Journal* and in sessions held at the Annual Meeting. Both are used as a forum in which public health leaders are continually putting forth new ideas which spring from their experience and foresight.

APHA is also active in special explorations. During the past three years a behavioral scientist has been employed on the staff to develop more recognition of the ways in which the social sciences can be useful in public health programs. The Professional Examination Serv-

ice is working on new methods for building effective testing procedures in the field of vocational counseling. An APHA-sponsored project at North Carolina University School of Public Health is determining the reasons why medical students select or reject public health as a specialty. All three programs are assisted by federal grants. The Statistics Section is producing a series of monographs that relates 1960 census population data to various socio-economic and morbidity information and that exploits for the public health administrator a potential that might otherwise lie long buried in official documents. A plan is being developed with the National Health Council that would establish a National Commission on Community Health Services to study community health needs and resources; following this study, new blueprints for the organization of local public health services would be provided.

In order to reduce the costly time lag between the discovery of new scientific data and its application in the field, the Western Regional Office of APHA (located at 693 Sutter Street, San Francisco) has developed a very successful continuing education project with the graduate school of public health at the University of California. With help from the National Institutes of Health and voluntary health organizations, this project makes regional institutes on newer program subjects available to many public health workers who might otherwise never have such opportunities.

Educating of Public Sentiment

APHA is a center of communications for new ideas and basic technical information of importance to the public. These flow in a steady stream in and out of the Association through the efforts of public health educators and their fellow APHA members. At its Annual Meeting APHA becomes another kind of information center, providing for nationwide news coverage of recent important developments in public health which are discussed at the scientific sessions. APHA also promotes and helps build more effective community health programs for the future by relating its work to other organizations (Association representatives sit on the working committees of some 50 such organizations), interested public leaders and the layman.

In addition, there is year-round participation by many interested laymen in both APHA and its Affiliated Societies' activities. In this, the 13,500 members and Fellows of APHA are joined by more than that number of members of APHA's 47 Affiliated Societies in the States and Puerto Rico and of its Regional Branches—Southern, Western, and Middle States. Many of the affiliate members are not able to attend meetings of the national organization or to participate actively on its committees. They can share in the works of societies within their own state or region, however, achieving deserved recognition through their activities and the offices to which they are elected.

Last year for the first time, health agencies, which derive substantial benefits from the work of APHA, were invited to join the Association. Twenty-one state and local official agencies have so far been elected to Agency Membership. Their support, along with that of state and local voluntary agencies, will help provide the support needed for continuing APHA's expanded program of balanced activities, regional offices, professional education and legislative liaison.

Since its establishment two years ago, the Washington, D.C., office of APHA (at 224 E. Capitol Street) has been concerned with two primary objectives: a close liaison with the Department of Health, Education, and Welfare and its various health agencies; and liaison with legislators and congressional committees to the end that sound technical and professional advice be available to them on any proposed health legislative matter. Some of the Association's and its affiliates' particular interests in the legislative field during the past few years have been additional federal aid for training in public health, both from the standpoint of assistance to the graduate schools and stipends for students; improved health facilities for migratory workers; extended community health services and facilities for the elderly and chronically ill; improved support for radiological health activities; and the consolidation of health responsibilities wherever possible within public health agencies.

APHA's international role is almost as old as the Association. Near the turn of the century Canada, Mexico, and Cuba were component members. These members still maintain close ties, and vice-presidents from Canada and from Latin America are elected each year. A Committee on International Affairs was appointed in 1959 and is currently exploring ways in which we can relate to our counterpart organizations in other lands.

* * * *

The APHA sprang from the recognized need of public health workers in many fields to pool their experiences, science and ideas through a professional association and so help the nation forward on its path to good health. Members and Fellows adhere steadfastly to the original objectives of the APHA, but continue to review them in the light of modern requirements. To this task a substantial number of the members give generously of their personal time and professional talents in committee work and section activity. Backing up their efforts are APHA's affiliates and a growing number of Agency Members which realize that their support of APHA is crucial to the expansion of the public health program in America. «

Berwyn F. Mattison, M.D., has been executive director of the American Public Health Association and managing editor of the *American Journal of Public Health* since 1957. He is a prominent member of a number of health and welfare associations and committees, including the National Committee on Alcoholism, the American Heart Association and the National Advisory Committee on Public Health Training.

I

Harry E. Walkup, M.D.
Director of Research

Harry E. Walkup, M.D., assistant director of the surgical service, Veterans Administration, Washington, D.C., has been appointed director of research of the American Thoracic Society-National Tuberculosis Association. He will assume his new post, in which he succeeds Floyd M. Feldmann, M.D., September 1.

Dr. Walkup will assist in the development of policy and be responsible for the administration of the ATS-NTA research program, and for maintaining liaison with and giving consultation to constituent and affiliated associations in connection with research.

Prior to going to the VA Central Office last February Dr. Walkup was chief of the surgical services and assistant director of professional services in charge of research at the VA Hospital in Oteen, N.C. He is a native of Mt. Hope, West Virginia, and received his medical degree from the University of Maryland School of Medicine. He has been active in the Southern Trudeau Society and has served on the ATS Committee on Research.

P

▸ ***Dr. Sidney H. Dressler,*** former medical director and chief of staff of the National Jewish Hospital, has joined the staff of the Tuberculosis Program of the U. S. Public Health Service. Dr. Dressler will serve as special assistant to the Chief of the Program.

He has served as a consultant to a number of state health departments and is past president of the Denver TB Society.

▸ ***George Ross*** has been named NTA chief of public relations, replacing ***Walter Murphy,*** who is now director of public relations for the National Council on Alcoholism. Mr. Ross conducted his own public relations firm from 1945 to the present, representing clients in the theater, motion pictures, television, industry and leading advertising agencies. He is a former *New York World-Telegram* columnist and has published articles in leading national magazines.

▸ ***Dr. O. A. Sander,*** NTA Board member from Wisconsin and member of the Committee on Respiratory Diseases, recently received the Knudson Award, one of the highest awards given by the Industrial Medical Association. This award, given each year to a physician considered to have made an outstanding contribution to industrial medicine, was presented to Dr. Sander because of his important and substantial contribution to the understanding of occupational pulmonary disease.

▸ ***Dr. Walter L. Bierring,*** one of the founders of NTA and former president of the American Medical Association, died on June 24 at the age of 92. Dr. Bierring was present at the Atlantic City meeting when the NTA was founded and by accident did not sign the list of founders. Through the years, he was an active member of the Iowa TB and Health Association. He was one of the organizers of the American Boards of Preventive and Internal Medicine and also a past president of the National Board of Medical Examiners and Health Authorities of North America.

▸ ***Dr. Camille Guerin,*** co-developer of the vaccine BCG, which has been used throughout the world in combatting tuberculosis, died on June 9 in his Paris home. He was 89 years old.

Dr. Guerin, along with Dr. Albert Calmette, developed BCG in 1925. In 1906, Dr. Guerin proved that resistance to TB was related to the presence of living bacteria.

▸ ***Dr. Francis M. Pottenger, Sr.,*** an honorary member of the American Thoracic Society, died in Lebanon Hospital, Los Angeles, on June 10. He was 91 years old.

A leading authority on tuberculosis, Dr. Pottenger was past president of the American Sanatorium Association, a forerunner of the ATS, and was one of the delegates to the Fifth International Congress (on tuberculosis) in 1905.

PRINTED IN U.S.A.

MRS. ELEANORE G. LIBN
VANDERBILT SCH. OF MED.
MED. LIBR.
NASHVILLE 5, TENN.